POWER OF ATTORNEY

STATE OF WASHINGTON

COUNTY OF _____

KNOW ALL MEN BY THESE PRESENT, that the undersigned, _____, PROVIDER'S NAME

of _____ County, Washington, does hereby make, constitute and appoint

_____ as attorney-in-fact for the benefit of the undersigned, and in its SUBMITTER'S NAME

name, place and stead for the following purposes:

To act as data processing agent for the undersigned in electronic submission of the undersigned's medical assistance claims to the Washington Department of Social and Health Services for purposes of reimbursement under the state's Medical Assistance Program;

To act as the undersigned's authorized agent for purposes of signing on behalf of the undersigned the following certification agreement in connection with the above described electronic submission of medical assistance claims:

"I do hereby certify that all information contained on the above described computer submission is true, accurate, and complete and that to the best of my knowledge, information and belief, the services for which medical assistance is sought have, in fact, been rendered by the provider, as claimed, and further, I understand and acknowledge that the department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, documents or the concealment of any material facts, is a crime under Federal and State law."

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

It is expressly acknowledged and recognized that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of the undersigned for the truthfulness and accuracy of any and all medical assistance claims submitted on

behalf of the Medicaid Provider by _____ to the Washington SUBMITTER'S NAME
Department of Social and Health Services.

This Power of Attorney is made effective this _____ day of _____, 20 ____ .

_____ SUBMITTER'S NAME	_____ PROVIDER'S NAME
_____ SUBMITTER'S ADDRESS	_____ PROVIDER'S ADDRESS
_____ SUBMITTER'S IDENTIFICATION NUMBER	_____ PROVIDER'S MEDICAID PROVIDER NUMBER

BY: _____
PROVIDER'S SIGNATURE

_____
NOTARY PUBLIC